Special Needs Project
External Services Form
Demonstration Site, County Commission

Child's name:

Name of person who completed this form: | Phone number:

1a. Service category (Select only one)	***1b. Service conducted (Select only one)***	
☐ Special Education	☐ Special instruction for the child ☐ Speech and language services ☐ Audiology services ☐ Psychological services ☐ Physical therapy ☐ Occupational therapy ☐ Assistive technology services ☐ Health services ☐ Service coordination ☐ Recreation services	☐ Social work services ☐ Family training, counseling, and support ☐ Orientation and mobility services ☐ Medical services for diagnosis and evaluation ☐ Nursing services ☐ Nutrition services ☐ Vision services ☐ Transportation services ☐ Other
☐ Mental Health	☐ Parent-child intervention ☐ Consultation ☐ Play therapy ☐ Psychiatric/medication ☐ Parent education/training ☐ Social skills training	☐ Behavioral aides ☐ Respite care ☐ Case management ☐ Crisis management ☐ Other

2. First date of service

(mm/dd/yyyy):

3. Program that provided service (Select only one) *This section will be customized to list the programs providing services.*

4. Occupation of service provider (Select only one)

☐ Audiologist	☐ Occupational therapist	☐ Social worker
☐ Child care provider	☐ Optometrist	☐ Special education teacher
☐ Early childhood teacher	☐ Paraprofessional	☐ Speech and language therapist
☐ Early intervention specialist	☐ Physical therapist	☐ Other
☐ Mental health professional	☐ Physician/pediatrician	☐ Unknown
☐ Nurse	☐ Psychologist	

5. Location of service (Select only one)

☐ Family home	☐ Family resource center	☐ Hospital or clinic
☐ Child care setting	☐ Other community setting	☐ Unknown
☐ Preschool	☐ Early intervention classroom or center	

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6. Service details

Start date (mm/dd/yyyy): ____________ End date (mm/dd/yyyy): ____________
Total contacts: [ ] Total service hours: [ ]

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Total contacts: [ ] Total service hours: [ ]

Discontinuation of services

7a. Have services been discontinued?

- ○ Yes
- ○ No
- ○ Don't know/Declined

7b. Why were the services discontinued? (Select only one)

- ○ Child no longer eligible because of age
- ○ Child no longer eligible because other circumstances
- ○ Treatment goals were met
- ○ Child moved
- ○ Parent decision to discontinue
- ○ Staff no longer available to provide service
- ○ Agency no longer available to provide service
- ○ Child entered kindergarten
- ○ Other
- ○ Service type, provider, or location changed

7c. Discontinued date

(mm/dd/yyyy):